Karen Ball, ND

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425-318-0255

Directive to release medical information

Patient Information:

_____ _____
Patient's name Date of birth

_____
Phone number

_____
Street Address City State Zip Code

I hereby request that my medical records, as marked,

____ Health records *Please specify* _____
____ Lab results *Please specify* _____
____ Imaging reports *Please specify* _____
____ Other *Please specify* _____

be sent from the office of:

Dr. _____, at_____
Clinic name

_____
Address City State Zip Code

_____ _____
Phone Fax

To the office of

Dr. Karen Ball
1750 112th Ave. NE, Suite E-165
Phone: 425-283-4928

Naturally Well
Bellevue, WA 98004
Fax: 425-283-4325

I hereby consent to release the records obtained in the course of my diagnosis and treatment**. I authorize communication between these health care professionals regarding my health care.** I understand that this authorization is valid for six months from the date of signing unless revoked in writing earlier.

_____ _____ _____
Signature (Patient, guardian, legal representative) Date Relationship to patient

Specifically Protected Information

I understand that a variety of tests have been undertaken and one of them may have been an HIV-related test. My signature below authorizes release of any test results including any HIV-related (AIDS) test results.

Signature: _____ Date: _____